

diately before the optical phenomena can not be considered here, as we know that frequently a typical attack of scotoma scintillans is unaccompanied by headache. Moreover, it is not clear in what relation the "rheumatism of the head" stands to this case. There is also absolutely no reason to believe that the phenomena were the premonitory symptoms of a subsequent paralysis or tabes.

In conclusion I would point out the transition of the elementary light phenomena of scotoma scintillans into real hallucinations, again confirming the afore-mentioned theory, that hemianopic hallucinations may be produced by a variety of localized excitations in the optical tracts and not in the occipital lobe only.

A CASE OF SPONTANEOUS PROLAPSE OF BOTH LACRYMAL GLANDS. REVIEW OF THE LITERATURE.

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THE case here reported is anomalous in character rather than of any practical interest. In looking up the number of similar cases which had previously been reported, and also any other literature bearing upon the subject, I was surprised to find that spontaneous prolapse of the lacrymal gland could be placed in the category of rare affections.

Several cases of traumatic prolapse have been reported, as also one or two cases of spontaneous prolapse of one lacrymal gland, but nowhere can I find the report of a case where both lacrymal glands have become spontaneously detached.

Mary M., colored, aged twenty-seven years and unmarried, presented herself at the clinic of the College of Physicians and Surgeons in September, 1902. She came with the complaint that both upper eyelids remained swollen since an attack of bronchitis three weeks previously. There was no pain and no interference with vision; practically no discomfort from the present condition.

On casual inspection the upper lids gave all the appearance of œdema, especially on the temporal sides. By palpation I found a well-defined glandular body just beneath the border and at the outer edge of the supraorbital ridge. It was especially prominent when the patient looked down and held the head forward. Both sides had absolutely the same objective appearance and symptoms. It was freely movable under the touch, and could be pushed up underneath the orbital rim. The patient was perfectly positive that there was nothing wrong with the eyes up to three weeks previously. No enlarged glands could be found in any other portion of the body. As the condition was giving the patient no trouble, she refused any operative interference, leaving out the question of its own advisability. When last seen there were no changes visible.

I was very confident, as were my colleagues, that the bodies felt were the lacrymal glands, but we could in no wise account for this dislocation. There was no history of traumatism to which it could be traced, nor any severe straining on the part of the patient except the previous cough.

In this latter respect, as well as in several others, the case is similar to the one reported by Snell in 1881.

Anatomists tell us that the lacrymal gland is enveloped in a capsule which, by its attachment to the periosteum of the orbital cavity, is retained in place. In a case of this kind we can but surmise some anatomical malformation or some relaxation of the surrounding tissues as a cause of such a pathological condition.

In looking up the literature of this subject but few cases could be found recorded. For this reason I will give in detail a résumé of all cases of both spontaneous and traumatic prolapse of the lacrymal gland of which I have been able to find any report.

CASE I.—In the *Ophthalmic Review* for the year 1881–82 we find a case reported by Simeon Snell, as follows:

On March 7, 1882, I was consulted by a tradesman, aged forty-five years, in consequence of a lump in the left eyelid. It had been observed first a week previous, and had been seen by Dr. Brook, who sent him to me. The swelling was distinctly visible, and particularly noticeable to the touch. Situated in the upper eyelid at its external part and coming from under the frontal bone, it was felt beneath the structures of the lid as about the size of an almond. It could be pressed between the fingers, but readily slipped back into the orbit. Its surface felt more smooth than irregular. Pressure causes it immediately to recede into the orbit beneath the frontal bone, but after depressing the head it was again found to be visible in the lid. This he had himself observed, and after several attempts to replace it he always found on bending the head downward that it had reappeared. He complained of it causing him discomfort, which was increased on manipulation.

On the night of the first appearance of the substance in the eyelid he had gone to bed in no wise ailing, and had detected it on rising in the morning. He had in the night been coughing a great deal. The same side of the head is marked by a large venous subcutaneous nævus which extends to the eyebrow and apparently passes into the orbit. The man is a free drinker, and is frequently laid up in consequence.

The question as to what the "lump" was did not present any great difficulty. Its situation, size, and feel suggested directly its being the lacrymal gland displaced, and this was the diagnosis also of the medical man who first examined the patient.

It was decided to try the effect of compression in keeping the gland in place. A few days later when the patient presented himself he desired to postpone the wearing of a "pad" for a short time. I, however, pressed the gland well back with my finger and kept it replaced. He left me without its having reappeared.

Being soon after laid up with one of his attacks of illness, he did not again see me until five or six weeks later. The swelling in the lid

was then no longer visible, and he asserted that it had not appeared since his last visit, and that the sense of discomfort had gone.

Spontaneous displacement of the lacrymal gland must, I imagine, be a very rare condition. I cannot recall a recorded case like the one described. I remember the case of a man under treatment for keratitis some years since in whom the glands were distinctly visible and freely movable in the eyelids. The condition was congenital.

I am further reminded by a gentleman attending my clinic of another similar case which came under observation since the one just referred to.

It is worthy of mention that in the case of my patient, in his attacks of illness following his drinking bouts, he sometimes suffered from epileptiform convulsions, during which the large venous nævus at the margin of the orbit became greatly distended, looking as though it were ready to burst.

CASE II. Reported by Wm. George Syme from the hospital practice of Dr. Argyll-Robertson in the *Edinburgh Medical Journal*, 1887, vol. xxxiii.—J. C., a man aged thirty-six years, applied for treatment in May 1887, suffering from ptosis and a tumor situated in the right upper eyelid. The tumor extended along the whole length of the upper lid, from a point above the inner to a point above the outer canthus. By its weight it caused ptosis; the eyelids were nearly closed, and the upper lid could hardly be raised at all, the mass catching at once on the orbital edge. The skin over the tumor, though slightly congested, was not oedematous, and was freely movable over it. The tumor, which felt firm, lobulated, and glandular, was not attached to the deeper structures except about the middle for a distance of one-third of an inch, where it was moored to the orbital edge of the frontal bone.

It could not be reduced into the orbit. The ocular movements were in no way affected, and the vision in the two eyes was the same. The tumor was perfectly painless even on firm pressure; the neighboring lymphatic glands were not enlarged, and the patient seemed to be in perfect health. The history of this affection was that about the end of January of this year the patient had first noticed the swelling about the size of a bean in the upper eyelid. This was painless, but troublesome on account of the ptosis which it caused. At this time also he noticed that the right eye was more watery than the left—a condition which had not previously been present, and the swellings were larger in the mornings and became rather smaller in the day. He thinks that the tumor had suddenly attained the size of a bean, but is not quite certain; at any rate it had steadily increased in size from the time of its first appearance. In the winter of 1885 the patient had noticed a similar swelling in the same situation; this however had been much smaller, and caused no annoyance, and after a few weeks spontaneously disappeared.

Under these circumstances the diagnosis was made of a displaced and chronically enlarged lacrymal gland. On May 10 an incision was made over the tumor in the long axis of the upper lid, and the

gland, which was lying immediately under the skin, was turned out. The accessory portion of the gland was found lying in the proper situation of the main part, and was left to carry on the usual functions of the gland. As soon as the swelling had subsided there was a marked diminution in the ptosis, which continued to improve until the patient left the hospital.

CASE III. Reported by Dr. Henry D. Noyes and published in the *Transactions of the American Ophthalmological Society*, 1886-87.—Miss Carrie S., aged twenty years, of Paterson, N. J., presented herself February 8, 1887, because of the swelling under the upper lid of the right eye which had been growing for nine years. For the last few months it had been uncomfortable. It rested upon the eyeball at its superoexternal side, and reached within 6 mm. of the cornea. It was flattened, not lobulated, and nearly circular in outlines, and merged gradually into the surrounding conjunctiva. A few vessels coursed over it, and it had a faint yellow color. It was nearly three-fourths of an inch in diameter. It could be moved freely upon and also moved with the globe. It was very compressible and elastic. It seemed to have a capsule which at its lower border was densely white and firm; over the remaining surface it was thin and translucent, but with a yellow tinge. There had never been any blow nor sign of disease in this region, nor inflammation, nor serious pain. The progress had been very gradual and the cause unknown. The other eye had been lost sixteen years before by accident. This globe was atrophied, yet on lifting the upper lid a rounded mass, red and slightly lobulated, and a little larger than a cherry-stone, appeared at the upper and outer angle of the orbit, and was regarded as a part of the lacrymal gland which had become displaced.

Treatment. An incision was made obliquely across the tumor and the conjunctiva dissected off by the closed blades of curved and sharp-pointed scissors. Very little cutting had to be done, and the hemorrhage was moderate. When the mass was separated it proved to be normal lacrymal gland.

The conjunctival wound was stitched and a bandage applied. The healing was prompt and the reaction moderate. A wrinkled and swollen condition of the conjunctiva remained for a few weeks at the site of the operation. The prolapse seems to have been caused by simple laxity of the enclosing fibrous capsules, without any propulsion from behind.

CASE IV. Reported by L. Mauthner in *Wien. med. Presse*, 1878, p. 110.—Man, aged twenty-four years, came to the clinic October 4, 1868, for inflammation of the eye of four weeks' standing, and for a tumor in the upper eyelid, first noticed a few days before. There was an injection of the conjunctiva palpebrarum et bulbi, ciliary injection, and diffuse coloring of the cornea; the upper lid was much thickened and drooping, and one feels in its lateral half a hard, movable, and slightly rough, painless tumor, not adherent to the skin, of size and form of the lacrymal gland. This showed no sign of an orbital tumor. By the use of atropine and compress bandage the inflammatory phenomena of the cornea disappeared in five weeks, but the tumor of the upper lid, which Jaeger thought might be the lacrymal gland, had not changed in spite of using iodide of potash and iodine salve. Jaeger operated November 11 1868; laid bare the tumor by section,

from in and above outward and somewhat down in the direction of the length of the tumor; a small part removed showed nothing abnormal. The gland was replaced in the orbit and made fast by sutures, the patient being discharged sixteen days after operation. The gland was fixed to surrounding tissues and only a small tumor could be felt at the lateral upper orbital edge.

CASE V. Reported by S. S. Golovine, *Clin. Maitop.*, Mosk., 1895, vol. v. pp. 930-941.—A young man, aged eighteen years, admitted to the hospital July, 1893. The upper eyelids seemed swollen and slightly drooping. He carried his head erect, and even from time to time threw it backward, as if he wished thus to compensate for the fall of the eyelids; he instinctively contracted the frontal muscle; from this cause the skin above the brows was constantly wrinkled, and the face had a very strange expression. The skin of the eyelids was tense, very delicate, and formed a fold almost transversal which came down on the eye. This was not equally pronounced in its entire extent. The crease which one generally finds below the orbital edge was effaced. The skin, of normal color, was transparent and allowed subcutaneous veins to be distinguished. These phenomena were symmetrical, but more pronounced on the left eyelid. Below the skin one might palpate a hard compact lump, like a grape, ovular, $1\frac{1}{2}$ cm. in diameter. It could be displaced in all directions and slid easily across the anterior surface of the cartilage. These movements seemed limited toward the interior by some adhesences, although it was impossible to feel them. The movements were freer upward and outward. When the finger was raised the body came back little by little from the orbit, falling into the part of the cutaneous sac, which covered the external commissure. The elevation of the lid was hindered and the patient overcame this difficulty by contracting the frontal bones. It was very easy to turn the lid back, the mucous membrane of which was altogether normal.

The lacrymal conduits were normal, although latterly the tears were less abundant. Although the other organs were not changed, the general organism seemed much depressed and its development much retarded. The lids had been changing for the last three years.

There were two methods of treatment: 1. Total extirpation of the gland. 2. To bring the gland back to its place and fix it. Both methods were used.

The writer began by removing the right lacrymal gland.

The result of the operation was very satisfactory, the wound healing by first intention. Eight days later the other eye was operated upon, the lacrymal gland being replaced in the orbit and fixed with sutures. The result was very good, and three days later the cutaneous sutures were removed, and six days later those which held the gland in position. Two years later the writer received a letter from the patient, who expressed himself as well pleased with the result.

CASE VI. Reported by Briere in *Bull. et mêm. de soc. de chir. de Paris*, 1876, vol. ii. p. 592.—Boy, aged eleven years. The affection began five and a half years ago. He struck his left temple against a nail. The wound suppurated and the external wall of the orbit began to necrose. The skin of the eyelid, temple, and brow, being drawn back by the cicatrix, was depressed to the walls of the orbit, which had become angular and unequal. The free edge of the eyelid, drawn more

and more up and out, took progressively a form characterized by an elongation of the free edge, which measured 22 mm. more than that of the healthy lid. This deformity, produced by numerous cicatricial bands, had, as a secondary result, compressed the lacrymal gland. This gland was not protected by the bony depression in which it was normally lodged. The opening of the lid, increasing more and more, the lacrymal gland was soon exposed. The lobules, not being compressed from this period, became larger and formed a tumor the size of a large hazelnut, between the lid and the globe.

Operation August 10th under chloroform.

1. The writer took the exact length of the healthy right lid, and from the internal angle of the diseased eye he measured this length on the elongated lid.

2. Incision between lid and lacrymal gland to mobilize the upper lid.

3. Dissection of the upper lid 4 to 5 cm. as far as the middle of the forehead; considerable bleeding.

4. Curved incision, separating the outer side of the lacrymal gland from the superfluous part of the lid which was to be excised.

5. Incision at 2 mm. outside of the ciliary line and parallel to the preceding except at the upper part.

6. Excision of the whole flap.

7. Dissection of the temporal flap, the longest and most difficult part of the operation.

8. He assured himself that union would be possible by sliding the two flaps.

9. Before applying the sutures he put on a compress bandage and allowed the patient to revive from narcosis.

10. Twenty minutes later, when hemorrhage had stopped, the lacrymal gland was replaced in the cavity which had been made by the removal of the sequestra of bone.

11. Applied twisted sutures with fine pins.

The operation may be considered a mixture of that of Adams and Jaeger.

It is now eight months since the operation. The lid covers the eyeball except the parts nearest the external commissure, where there is a space of 2 mm. between the lids when the lids are closed. The lacrymal fistula has closed spontaneously; there only remains a slight depression of 2 mm. in length, the bottom of which is healthy looking.

CASE VII. Reported by G. Ahlstrom, in *Centralbl. f. prakt. Augenheilk.*, 1898, vol. xxii. p. 300.—The patient, a boy aged twelve years, fell when he was three years old and struck his right eye upon a sharp-cornered block of ice. There was a bloody wound which soon healed. When first seen there was found to be quite a high-grade ptosis of the right eye, so that in looking straight out the upper lid covered half of the pupil. The ptosis had been caused by the thickness of the lid. The skin of the lid was normal, easily movable, and hung on the palpebral edge in the form of a fold a little below the edge; no scar was to be seen. By palpation one could perceive a tumor-like mass just below the skin, about the size of an almond. This was quite firm, somewhat ragged, showing no adherence with the deeper parts, but was easily movable under the skin, and could not be pressed into the orbit. The tumor was removed. It was found to be the lacrymal gland.

The ptosis became less immediately after the operation and the lid resumed its normal appearance.

CASE VIII. *Bericht d. k. k. Krankenh. in Wien*, 1889.—A very superficial mention is made of this case. A laboring man, aged forty-one years, was transferred to the ward. He had suffered from a scrofulous (?) conjunctivitis, and also had had an ulcer of the same nature on the upper eyelid. As a result of this latter there was a depression and strangulation of the lacrymal gland and ectropion, by which the upper lid adhered in about its middle to the edge of the orbital cavity as a part of the lacrymal gland, being in this way removed. The remainder of the gland is seen as a strangulated tumor. Separation of the adherence to the edge of the orbit, the transplantation of the flap from the temple region, resulted in a cure.

CASE IX. Reported by von Graefe, *Arch. f. Ophthalmol.*, 1866, vol. xii. p. 224.—Boy, aged ten years, was brought to Graefe on account of a wound of the upper eyelid, having been struck the day before by falling on a piece of glass. There was a wound 18 mm. long which passed through the whole thickness of the upper lid parallel with the edge of the orbit. From the wound there arose a reddish plug about the size and shape of a finger phalanx, which he recognized as the lacrymal gland. It hung down over the cleft of the lids, which it partly covered and was somewhat drawn in at its base, so that the physicians thought of removing the whole mass. The prolapsed lacrymal gland was held back by an assistant while Graefe closed the wound with four stitches and then applied a compressive bandage. There was a slight suppuration, and in the end there was left a fistula of the lacrymal gland.

CASE X. Mentioned by Panas in his *Lecons sur les Affections de l'appareil lacrymal*, Paris, 1877, p. 8.—A case similar to that of von Graefe was shown by Lariboisière at a clinical meeting. There was a deep contused wound in the left upper lid just at the external extremity of the orbital ridge, in which was seen a prolapsed lacrymal gland. A single stitch of metal suture was enough to keep the gland in place and bring on cicatrization of the edges of the wound, which was $2\frac{1}{2}$ cm. long. When the patient left the hospital there was a slight induration of the gland which would probably disappear in time.

CASE XI. Reported by R. Rampoldi, *Ann. di Ottamol.*, Pavia, 1884, vol. xiii. pp. 68-70.—Boy, aged twelve years, admitted to the hospital in January, 1880, for grave ectropion of the upper lid. About a year before he had been struck by a stick in the left temporoparietal region, followed by pronounced exophthalmos. He was taken to an eye clinic, where a diagnosis of retrobulbar phlegmon was made, the abscess opened, and the exophthalmos thus much reduced. The vision was preserved intact, and the patient returned home almost completely cured. A slow process of the osteoperiostitis went on in the orbit, the drainage aperture becoming fistulous and discharging slowly disintegrated grayish pus, while the cicatrix adhering to the brow of the orbit turned back the aperture of the fistula and drew the lid strongly upward and outward, turning the free margin so that the externo-superior conjunctiva was all turned out. The patient, in a very anæmic state, was now admitted in the hospital. The exophthalmos was moderate and the bulb turned out in a limited degree only. The cicatrix was strongly adherent and had a tendency to invade the lac-

rymal fossa. A local treatment was used with disinfectants and the Paquelin cautery, supplemented with a liberal diet and tonics. After some time the patient left the hospital before it was thought best to attempt a radical cure.

In August, 1880, the palpebral ectropion was considerably increased, and at the site of the wound was seen a tumor of solid consistence of the size and shape of a wild mulberry, which was recognized as a dislocated lacrymal gland. As it was impossible to replace it, the tumor was destroyed with the needles of Boerelli.

CASE XII. Reported by R. Hilbert. *Klin. Monatsb. f. Augenheilk.*, vol. xxxviii. p. 478.—Boy, aged one and one-half years, was brought to the writer December 28, 1889, whose left eye was said to have been injured the day before by his falling on a beam. Close to the outer left lid commissure just under the edge of the orbit was a wound 1 cm. long, horizontal, and from which protruded a red roundish body about the size of an almond. The whole lid was black and blue. From the article of Ahlstrom the writer considered the tumor to be a lacrymal gland. He removed it with one stroke of the scissors, closed the wound with two stitches. Healing followed promptly; there was no ptosis, and the microscopic examination showed the correctness of the diagnosis.

CASE XIII. Reported by Goldzieher, *Jahresber. u. b. Leist. u. Fortschr. im Gebiete der Ophthal.*, Tübingen, 1878, vol. vii. p. 466.—A child, aged one year, was wounded in the upper eyelid, which was followed by bleeding and the appearance in the wound of a dark-red, fleshy body. When the writer first saw the patient this body was the size of a hazelnut and completely filled the skin wound, which was 4 mm. long. This body was cut off with the scissors and the wound healed promptly. An examination of the growth removed showed it to be the lacrymal gland.

CASE XIV. Reported by Haltenhoff, *Annales d'oculistique*, 1895, pp. 319-321.—This was the case of a boy, aged two and one-half years, who fell forward in a road filled with broken stones. When he got up he could not open his eye, and in the lid appeared a wound from which protruded a solid bleeding mass. The upper lid was bandaged, and three days later was seen by the writer. The upper lid was found to be falling over, oedematous, tense, and quite ecchymotic. In its external third, several millimetres above the free border, there was a sort of fleshy protuberance of a livid grayish-red color and of a consistency which seemed to be firm for a simple clot. It adhered by a sort of pedicle to the bottom of a horizontal wound of the skin. The patient was etherized and the palpebral fissure opened enough to prove the integrity of the eyeball. It was then decided that it was a hernia of the lacrymal gland. The sharp edge of a broken stone had cut the lid wide open, penetrated obliquely from below upward through the wound. The three days' strangulation rendered it difficult to reinstate the protruded gland, so the author profited by the narcosis and cut it off from the lid. It was then noticed that at the bottom of the wound there were several grayish-red lumps, apparently lobules of the gland. They belonged to the palpebral portion which is formed by a mass of little isolated lobules with loose connections. The wound was united with two silk sutures, dressed with dermatol, the wound closing by first intention except at one small point. The recovery was perfect,

and no difference was noticed in the appearance and moistening of the two eyes. Microscopic examination by Dr. Buscarlet confirmed the diagnosis.

CASE XV. Reported by L. Pistis in *Annales d'oculistique*, 1895, pp. 468-470.—J. D., aged one year. The child had fallen on her face in a road filled with stones, and the lid was cut near the external orbital border. The wound was on the upper lid of the left eye, and was cedematous and ecchymotic. The skin was intact only near the internal portion; the remainder was a bleeding surface with an almost triangular flap detached from the external third of the orbital border and turned downward. Through the lips of the wound, by a short pedicle, there appeared an oval gray mass. On raising the lid the writer found the cornea intact, and there was no exophthalmos. The gray mass was the orbital lacrymal gland. The writer reduced the prolapsed gland by suturing the lid in front of it, his observation differing in this point from that of Dr. Haltenhoff, who excised the protruding gland. Union took place by first intention, and as a result the child has only a slight prominence in this region as if the gland had not perfectly resumed its anatomical position.

CASE XVI. Reported by W. F. Mittendorf, in *Transactions of the American Ophthalmological Society*, 1901, p. 382.—A young lady, aged twenty years, in pretending to be hypnotized by her brother, fell forward and struck his hand in such a manner that his index finger struck the upper part of the outer corner of her left eye. The next day the young lady found that there was a swelling in the upper temporal part of the eyeball, which hardly showed with the lids in the normal condition, but became very apparent by raising the upper lid. As the swelling did not diminish, the patient consulted the writer. The eye showed apparently no injury except a slight scratch of the finger-nail near the inner corner, the rest being perfectly normal, and so was the vision of the eye, nor was the motility interfered with in any way. The tumor itself was slightly painful to the touch and could be pushed up a little, but descended immediately as the pressure exerted upon it was relaxed. The upper and the outer part of the orbit felt a little tender, but no perceptible difference of the two sides could be made out. The diagnosis of dislocation of the lacrymal gland was immediately suggested from these symptoms.

The treatment of the case was simply expectant, as pressure failed to replace the swollen part and as it caused no visible deformity. The swelling has remained practically the same now after a lapse of three months.

The diagnosis of these cases of dislocated lacrymal glands is apparently easy, and especially so when there is any incised wound permitting easy inspection in addition to palpation.

In all of the cases reported, except the one by Mittendorf and Noyes, the deformity was noted externally rather than internally beneath the upper lid. In my own case nothing abnormal could be seen by the closest inspection beneath the lid.

Cases of spontaneous dislocation of the gland will, of course, present but one or two symptoms which are found when the conditions are due

to trauma. With the exception of the deformity due to swelling and a possible limitation in the raising of the lid, these spontaneous cases usually cause no inconvenience to the patient.

It is a noteworthy fact that in none of the cases recorded has the lacrymal function of the gland been impaired, for in my own case neither an increase nor a decrease of the moisture could be noticed. Another remarkable symptom mentioned only in the case reported by Haltenhoff, where even the greater portion of the gland was removed, was the fact that there was no difference in the moisture in the two eyes.

The question of treatment must of course vary according to the character of the case. In those dependent on traumatism, where there is a contused or incised wound complicating the condition, operative intervention must always be considered. In those cases where there is no wound, or in the so-called spontaneous dislocation, the question of operation must be decided by the character of the individual case.

Mechanical compression is difficult of application. If the deformity is not marked and there are no uncomfortable symptoms, I do not see why it is necessary to do anything whatever. If there is ptosis from the presence of the gland, or if the latter should be painful and of great discomfort to the patient, fixation should first be attempted, and if that failed, there is no reason why the gland should not be removed.

ACUTE SUPPURATIVE THYROIDITIS.

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ACUTE suppurative thyroiditis is a very rare condition, and usually secondary to some infectious disease. As a primary condition it has only been recorded in a very small number of cases. A case belonging to this class came under the writer's observation and gave the following history:

F., aged forty years, a native of Italy, laborer by occupation, was admitted to the service of Dr. Parker Syms, at the Lebanon Hospital, on November 26, 1902. On account of the patient's inability to speak English, a good history could not be obtained. As far as could be learned, the patient was suddenly taken with a chill and high fever on November 23, 1902. He became gradually worse, and after two days was brought to the hospital. On admission his temperature was 103.2° F., pulse 128. He seemed in a state of profound sepsis, sweating profusely and being decidedly cyanosed. On examination, a diffuse swelling was found around the anterior portion of his neck, extending from the suprasternal notch to the upper border of the cricoid cartilage. There was some redness around the most prominent portion of this